U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 08 November 2006

CASE NO. 2004-BLA-5948

In the Matter of

R.A.F., JR.,
Claimant

v.

BETHENERGY MINES, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

R.A.F., Jr., *pro se*
For the Claimant

John J. Bagnato, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by R.A.F., Jr., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on June 24, 2002 (DX 2), the new regulations are applicable (DX 53).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on February 28, 2006, in Hollidaysburg, Pennsylvania. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Furthermore, Claimant was provided an opportunity to obtain and submit the report of Dr. Malhotra, whom Claimant had initially selected as a qualified provider to conduct his pulmonary evaluation, by March 31, 2006 (TR 13-16, 29; *see also* DX 10). However, Dr. Malhotra's report was not submitted into evidence. Moreover, the record establishes that Claimant subsequently selected Dr. Khan as the qualified provider to conduct his pulmonary evaluation (DX 11). Furthermore, as discussed below, Dr. Khan's report was submitted and received in evidence (DX 16). In addition, the record was held open to allow for the submission of written closing arguments by the respective parties to be postmarked no later than April 15, 2006 (TR 29). The record consists of the hearing transcript, Director's Exhibits 1 through 53 (DX 1-53) and Employer's Exhibits 1 through 3 (EX 1-3).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony admitted, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On June 24, 2002, Claimant filed the current application for black lung benefits under the Act (DX 2). Following Claimant's alleged assertion that he would not attend any examination requested by the Employer, the District Director issued an "Order to Show Cause Abandonment of Claim/Denial," dated October 15, 2003 (DX 43). In light of Claimant's failure to respond to the Order to Show Cause, the District Director issued a "Proposed Decision and Order Abandonment of Claim," dated December 4, 2003 (DX 45). However, Claimant filed a timely request for a formal hearing (DX 47). Accordingly, this matter was referred to the Office of Administrative Law Judges for adjudication (DX 51-53). Moreover, I find that Claimant did, in fact, undergo examinations pursuant to Employer's request (DX 33; EX 1). Accordingly, I find that Claimant did not abandon his claim, and I will consider this matter on its merits. As previously stated, a formal hearing was held on February 28, 2006, and the record was held open until April 15, 2006 (TR 29).

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?

(DX 51; TR 9).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

Claimant represented that he engaged in coal mine employment for 18 years (DX 2, TR 18). Employer does not contest Claimant's assertion (DX 51). Accordingly, I find that Claimant has established 18 years of coal mine employment.

B. Date of Filing

Claimant filed the current claim for benefits under the Act on June 24, 2002 (DX 2). There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). The presumption has not been rebutted.

C. Personal, Employment, and Smoking History

Claimant was born on March 20, 1942. He has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife (DX 2; TR 19-20).

As stated above, Claimant engaged in coal mine employment for 18 years. Claimant stopped working as a coal miner in 1990, because the mine shut down (DX 2; TR 18-20). Although Claimant initially stated that he would still be working today if the government had not shut down the mines (TR 18), he subsequently testified that he could not return to the coal mines because of his breathing, diabetes, stress, and the mines shutting down (TR 23).

Claimant testified that he worked as a roof bolter for most of his employment. However, his last usual coal mine job was as a mechanic (TR 18). His coal mine work was mostly underground, where he was exposed to coal dust. It entailed lifting roof jacks, some weighing up to 100 pounds, and work in dusty conditions (TR 22-23). After leaving coal mine employment when the mines shut down, Claimant worked as a car salesman for about 10 months. Claimant stated that this change in employment was very stressful and that he nearly suffered a nervous breakdown. Moreover, Claimant testified that he receives Social Security disability benefits for a schizophrenic disorder (TR 18-19).

Claimant stated that he suffers from shortness of breath on exertion, such as climbing steps, continued walking, or any stressful activity. However, he also testified that a nasal septal operation helped his breathing and allergies. In addition, Claimant stated that he was hospitalized for a heart cauterization, and that he also still suffers from diabetes (TR 20-21). Claimant takes medication for diabetes, allergies, stress, and schizophrenia, but not for shortness

of breath (TR 21-22). Although Claimant mows his own lawn with a self-propelled mower, he does not play any sports (TR 24). Claimant acknowledged a cigarette smoking history of one pack per day beginning when he was 16 years old and ending at age 30 or 32 (TR 24-25).

II. Medical Evidence

The medical evidence includes various chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, which are summarized below.

A. Chest X-rays

The record contains interpretations of chest x-rays, dated June 12, 2003 (DX 33), June 26, 2003 (DX 16), and November 29, 2004 (EX 1).

None of the foregoing are positive for pneumoconiosis under the classification requirements set forth in §718.102(b). To the contrary, the June 12, 2003 x-ray was read by Dr. Fino as completely negative (DX 33). Dr. McNiesh's descriptive interpretation of the x-ray, dated June 26, 2003, indicates "no infiltrates or effusions" (DX 16).[2] Furthermore, the x-ray, dated November 29, 2004, was interpreted by Dr. Pickerill as completely negative (EX 1). Dr. McNiesh is a Board-certified radiologist (DX 16). Moreover, Drs. Fino and Pickerill are both B-readers (DX 33; EX 1). In view of the foregoing, I find that Claimant has not established the presence of pneumoconiosis on the basis of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies, dated June 12, 2003 (DX 33), June 26, 2003 (DX 16), and November 29, 2004 (EX 1). None of the studies (before or after bronchodilator) are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. In view of the foregoing, the pulmonary function study evidence does not support a finding of total disability.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The record includes arterial blood gas studies which were administered on June 12, 2003 (DX 33), June 26, 2003 (DX 16), and November 29, 2004 (EX 1). None of the studies (resting or exercise) are qualifying under the regulatory standards set forth in 20 C.F.R.

[2] Dr. Ranavaya, a B-reader, reread the June 26, 2003 x-ray for film quality only, and noted "2" – "ovepenetrated." This represents a film quality which is "Acceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis" (DX 16).

Part 718, Appendix C. Accordingly, the arterial blood gas study evidence does not support a finding of total disability.

D. Physicians' Opinions[3]

The case file contains various medical records regarding Claimant's cardiac catheterization, acute sinusitis, endoscopic sinus surgery, and septoplasty (DX 12, 13, 14, 15). For the purpose of this black lung claim, however, the more relevant medical opinion evidence consists of the reports and/or deposition testimony of Drs. Fino (DX 33; EX 2), Khan (DX 16), and Zlupko (EX 1, 3).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, examined Claimant on June 12, 2003 (DX 33). In a report, dated July 3, 2003, Dr. Fino set forth Claimant's patient profile, occupational history, symptoms, past medical history, family history, and review of systems. Furthermore, on physical examination, Dr. Fino reported no abnormalities on examination of the lungs. In addition, Dr. Fino reported a 0/0 classification on chest x-ray, as well as "normal" lung volumes, diffusing capacity, oxygen saturation, carboxyhemoglobin level, and resting blood gases. In view of the foregoing, Dr. Fino concluded:

1. There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.

2. There is no respiratory impairment present.

3. From a respiratory standpoint, this man is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort.

4. Even if I were to assume that this man has coal workers' pneumoconiosis, conclusions #2 and #3 would remain the same.

(DX 33).

Dr. Fino testified at a deposition held on May 24, 2004 (EX 2). Dr. Fino stated, in pertinent part, that he had reviewed the objective data obtained by Dr. Begley and Dr. Khan's report (EX 1, pp. 10-13). Dr. Fino reiterated that he would not make a diagnosis of coal worker's pneumoconiosis or lung disease at all. Moreover, even if Claimant's last coal mine job entailed very heavy labor, Dr. Fino found that Claimant retains the pulmonary capacity to do such work (EX 1, pp. 13-16).

[3] Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See, Harris v. Old Ben Coal Co.*, 23 BLR 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc).

Dr. Ahmad H. Khan, who is Board-certified in Internal Medicine, examined Claimant on July 17, 2003. However, the underlying clinical test results reported by Dr. Khan were conducted by Dr. Begley on June 26, 2003 (DX 16). On a U.S. Department of Labor form, Dr. Khan referred to an attached Employment History form, dated June 24, 2002 (DX 16, Sec. B; *see* DX 3). In addition, Dr. Khan set forth Claimant's family, medical, and social histories. The latter included a cigarette smoking history of 1 pack per day from 1958 to 1973 (DX 16, Sec. C3). Furthermore, Dr. Khan set forth Claimant's subjective complaints of sputum and ankle edema (DX 16, Sec. D). On physical examination of the thorax and lungs, Dr. Khan reported findings within normal limits (DX 16, Sec. D4). In addition, Dr. Khan summarized the results of clinical tests conducted on June 26, 2003, as follows:

Chest X-ray	No worrisome findings
Vent Study (PFS)	↑ FEF 25-75 p[ost] bronchodilator → c/w obstructive small airway disease
Arterial Blood Gas	Satis oxygenation. Mild Meta Alkalosis
Other: EKG	…may represent old inferior wall MI…

(DX 16, Sec. D5).

Under the Cardiopulmonary Diagnosis section of the form report, Dr. Khan stated: "Mild small airway obstructive disease based on PFTs with slight post-bronchodilator response / improvement." (DX 16, Sec. D6). When asked the etiology of the cardiopulmonary diagnosis and provide the rationale, Dr. Khan noted: "Probable tobacco & coal dust exposure" (DX 16, Sec. D7). In response to the form question regarding the severity of Claimant's impairment and the extent to which the impairment prevents him from performing his last usual coal mine job, Dr. Khan stated: "minimal functional impairment" (DX 16, Sec. D8a). When asked to specify the extent to which the cardiopulmonary diagnosis contributes to Claimant's impairment, Dr. Khan stated: "difficult to ascertain based on minimal functional impairment. Other etio need to be ruled out!" (DX 16, Sec. D8b). In addition, Dr. Khan reported that Claimant suffers a moderate impairment due to "DM" (*i.e.*, Diabetes Mellitus). (DX 16, Sec. D9).

Dr. George M. Zlupko, who is Board-certified in Internal Medicine, and has limited his practice to pulmonary disease since about 1977 (EX 3, p. 9), examined Claimant on November 29, 2004 (EX 1). Dr. Zlupko issued a report, dated January 19, 2005 (EX 1), in which he set forth Claimant's chief complaint of shortness of breath, history of present illness, past medical history, family history, and, social history. Furthermore, on physical examination, Dr. Zlupko reported "clear" findings on auscultation and percussion of the chest. In addition, Dr. Zlupko cited the 0/0 chest x-ray reading by Dr. Pickerill; normal results and/or mild reductions on various parts of pulmonary function studies; and, normal arterial blood gases. In summary, Dr. Zlupko stated:

IMPRESSION: [The Claimant] has a very mild obstructive ventilatory impairment noted primarily as a slight reduction in lower lung volumes. His lung volumes are normal. His diffusing capacity is slightly reduced. Arterial blood gases on room air are normal. There is no evidence of any pneumoconiosis on chest X-ray. For all of these reasons, I feel that this patient

does not have anything to suggest pulmonary function impairment on the basis of any illness and clearly does not appear to have any evidence to suggest disabling pneumoconiosis.

(EX 1).

In his deposition testimony on January 12, 2006, Dr. Zlupko discussed his own findings, as well as the reports by Drs. Fino and Khan, respectively (EX 3, pp. 10-17). Dr. Zlupko reiterated that, in his opinion, Claimant does not have any evidence to suggest pneumoconiosis, certainly not disabling pneumoconiosis. In fact, Claimant does not have any disabling pulmonary dysfunction of any form (EX 3, p. 12). Moreover, Dr. Zlupko agreed with Dr. Fino that there is insufficient objective medical evidence to justify a diagnosis of coal worker's pneumoconiosis and that Claimant is neither partially nor totally disabled from returning to his last coal mine job from a respiratory standpoint (EX 3, pp. 16-17).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, all of the x-ray interpretations are negative for pneumoconiosis. Accordingly, I find that Claimant has not established the presence of pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As stated above, the relevant medical opinion evidence consists of the reports and/or depositions of Drs. Fino (DX 33; EX 2), Khan (DX 16), and Zlupko (EX 1, 3), respectively. As fact-finder, I have conducted a qualitative assessment of the conflicting medical opinion evidence by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning. All of the above-named physicians are Board-certified in Internal Medicine. However, only Dr. Fino is Board-certified in Pulmonary Disease. Therefore, I find that Dr. Fino has superior pulmonary qualifications.

However, even assuming the respective credentials of the physicians were identical, I would still find that Claimant has failed to establish the presence of pneumoconiosis and/or a totally disabling pulmonary or respiratory impairment.

As outlined above, among the above-named physicians, only Dr. Khan suggested the possibility that Claimant suffers from "legal pneumoconiosis," by reporting that Claimant has a mild small airway obstructive disease which is probably related to tobacco and coal dust exposure (DX 16, Secs. D6 & 7). However, Dr. Khan's finding is equivocal. Moreover, Dr. Khan only found a "minimal functional impairment" and stated that it is difficult to ascertain the etiology of such a minimal functional impairment, while noting that other etiologies must be ruled out (DX 16, Sec. 8). Therefore, I accord Dr. Khan's opinion little weight regarding the pneumoconiosis issue, and find that his opinion does not support a finding of total disability. Moreover, Drs. Fino and Zlupko opined that there is insufficient objective medical evidence to establish the presence of pneumoconiosis, and, that Claimant retains the pulmonary and respiratory capacity to perform his last usual coal mine job or comparable work (DX 33; EX 1, 2, 3). Their opinions are consistent with the objective medical evidence, including normal findings on physical examination, negative chest x-rays, nonqualifying pulmonary function studies which show little, if any impairment, and normal arterial blood gas results. In view of the foregoing, I find that Claimant has failed to establish pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. Since the weight of the x-ray evidence and medical opinion evidence fails to establish the presence of pneumoconiosis, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997); *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000).

Causal Relationship

Since Claimant has failed to establish the presence of (clinical or legal) pneumoconiosis, he also cannot establish that the disease arose from his coal mine employment. If Claimant had established the existence of pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203.

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart

failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As stated above, none of the pulmonary function studies or arterial blood gas tests are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendices B and C. Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(i) and §718.204(b)(2)(ii).

The record does not establish the presence of cor pulmonale with right-sided heart failure. Accordingly, Claimant has also failed to establish total disability pursuant §718.204(b)(2)(iii).

Finally, as outlined above, none of the physicians of record found that Claimant suffers from a totally disabling pulmonary or respiratory impairment. Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(iv), or by any other means.

Total Disability Due to Pneumoconiosis

Since Claimant has failed to establish the presence of pneumoconiosis and/or that he suffers from a total (pulmonary or respiratory) disability, he clearly cannot establish total disability due to pneumoconiosis, as defined in §718.204(c).

Conclusion

Claimant has not established the presence of pneumoconiosis; nor has he established that he suffers from a total (pulmonary or respiratory) disability. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

ORDER

It is ordered that the claim of R.A.F., Jr. for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601,***

Washington, D.C. 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).

Notice of public hearing: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. §932(a) (incorporating U.S.C. §932(b)); 20 C.F.R. §725.464. Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. §552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). Although 20 C.F.R. §725.477(b) requires decisions to contain the names of the parties, it is the policy of the Department of Labor to avoid use of the Claimant's name in vase-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.